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POLICY REVIEW

UNICEF HEALTH POLICIES AND STRATEGIES: SUSTAINABILITY, INTEGRATION AND NATIONAL CAPACITY-BUILDING

SUMMARY

Prepared in response to Executive Board decision 1991/11 (E/ICEF/1991/15), the present report addresses the issues of sustainability, integration and national capacity-building in UNICEF health policies and strategies. It reviews the evolution of UNICEF policy and practice, with special emphasis on immunization, the Bamako Initiative, programme integration and national capacity-building. It also discusses the conceptualization of these concerns with a view to further strengthening UNICEF programmes of cooperation. Based both on UNICEF experience and on evolving concepts, the report identifies the key aspects of and strategies for achieving sustainability. The annex contains an inventory of national capacities essential for sustainability of actions to improve health in developing countries.

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INTRODUCTION

1. Sustainability of systems and programmes has been a principal concern of UNICEF and the Executive Board for several years. In its decision 1991/11 (E/ICEF/1991/15), the Board considered that an important goal of UNICEF should be to assist Governments to develop sustainable, integrated national health care systems that meet the priority needs of their people, including but not limited to the needs of children. The Board stressed the need for the quantitative health sector goals adopted by the World Summit for Children to be adapted at the country level to national needs and circumstances and pursued through strategies integral to the development of sustainable health care systems. The Board also requested the Executive Director to report in 1992 on the extent to which UNICEF programmes support and strengthen national integrated health care systems.

2. In the light of the Board's request for a policy review, UNICEF used the opportunity to review its experience in health sector programmes, especially the issues of sustainability, integration and national capacity-building in the context of national health care systems. In preparing the present report, the secretariat held wide-ranging consultations with UNICEF development partners, including the World Bank, the World Health Organization (WHO), selected representatives of bilateral development assistance agencies and developing countries and knowledgeable specialists.

3. The present report reviews the conceptualization of sustainability, in addition to integration and national capacity-building for health programmes, based on UNICEF experience and with a view to further strengthening UNICEF programmes of cooperation through the incorporation of these elements. Sustainability is crucial because any programme that does not have a lasting impact on the people it is designed to reach is less likely to help meet long-term national development objectives.

I. THE 1980s: A DECADE OF DIRE NEEDS AND CHALLENGES

4. The economic decline of the 1980s had a negative impact on the developing world; average income fell by more than 10 per cent in Africa and Latin America and the already severe inequity of development in the world worsened. Although 50 of 78 developing countries experienced negative growth, only 2 of 28 industrialized nations did so. There was a net transfer of resources worth billions of dollars a year from developing countries to industrialized countries by the end of the decade.

5. The global recession, debt-servicing and structural adjustment programmes led to severe reductions in social expenditures in many developing countries, especially in the areas of health and education. The critical shortage of finances led to the rapid deterioration and collapse of social structures in many countries, especially in Africa. The proportion of public expenditure allocated to health fell to levels that were only one half of those of the

early 1970s. For example, in Uganda, public expenditure for health in 1988-1989 was only 16.9 per cent of the 1970 level, while the United Republic of Tanzania saw a drop of 30 per cent in health expenditures between 1980 and 1985.

6. In many of the poorest countries, particularly in Africa, health structures in rural areas ceased to function and were often abandoned owing to the lack of even the most basic drugs and operating funds and the non-payment or long-delayed payment of salaries. Even when they were paid, salaries were inadequate because of high inflation and erosion of the value of money. As a result, both preventive and curative services were affected.

7. The remaining public sector services were restricted for the most part to capital and major cities, except for missionary hospitals and clinics that continued to function in both urban and rural areas through the payment of fees by patients and external support. The provision of health care through private practice became common and was often carried out "after hours" in public facilities. However, because of the cost, it was restricted to the wealthier people who could afford such care or to those who were more seriously ill. The poor - the majority of the population - tended to resort more to traditional healers, drug peddlers and drug stores that often were not reliable or effective.

8. In the face of this deteriorating situation, various forms of external support were provided. Some donors continued to support the maintenance of city-based hospitals, mainly through capital investment, while a few channelled their support to peripheral areas through such elements as the construction of clinics, the provision of basic drugs, staff training and the development of management systems. Several non-governmental organizations (NGOs) also reoriented their support to the periphery with a district strengthening approach.

9. Very few donors were involved in promoting sector reforms, and health sector reform was thus influenced by structural adjustment. However, as the concept of "adjustment with a human face" gained acceptance, the World Bank increased its social sector lending, especially for health. In many instances, an overly economic approach to health sector development has led to distorted reforms, such as the indiscriminate application of cost-recovery mechanisms, without paying sufficient attention to ensuring adequate patient care and to increasing the overall efficiency of the health care system.

10. During the same period, UNICEF focused its attention on child survival and development (CSD), with the primary mission of saving children from unnecessary and preventable deaths and illnesses. The CSD "package" focused on growth monitoring, oral rehydration therapy (ORT), breast-feeding, immunization, food supplementation, family (birth) spacing and female education. However, immunization and ORT became more prominent for several reasons, including the possibility of setting quantifiable goals that were relatively easy to monitor, readily available technology, the relative ease of its implementation and its low cost. They were also the most effective direct

interventions for reducing child mortality because, as low-cost and affordable interventions, they promised a greater impact with a relatively small investment. WHO estimated that by 1990, 3.2 million lives had been saved each year through immunization and another 1 million lives through ORT and the control of diarrhoeal diseases.

11. The successful achievement of universal childhood immunization (UCI) led to the revitalization, strengthening and extension of health systems in many countries. Immunization services of some countries now reach more people than their postal systems. In Bangladesh, immunization services now reach 4,500 unions (a group of 6 to 20 villages), while formal health structures serve only 3,000 unions. The Government of Uganda has stated that immunization and essential drugs saved the public sector health care system during two decades of physical and economic disintegration. The most significant factor in the provision of immunization services in Uganda was not only the mobilization of resources, but also the fact that it gave a clear sense of purpose to local health workers. Essential drugs, where available, have provided the motivation for consumers to continue to use public sector services. In terms of infrastructure, the expansion of primary health care (PHC) units in Sierra Leone from 350 to 700 units has been attributed specifically to the extension of immunization services. In all countries, these immunization structures, whether fixed or mobile, have also led to improved work processes for local health workers through the clear definition of catchment areas and target populations, detailed planning, the organization of outreach systems, maintenance of the cold chain, information management, supervision and community mobilization.

II. EMERGING ISSUES AND RESPONSES

12. In view of the continued economic deterioration or slow economic recovery in developing countries, by the end of the 1980s, two critical issues had emerged:

(a) How to sustain the health services that had been established and the achievements made during the decade;

(b) How to revive and strengthen the public sector health care delivery system to meet a broader range of health needs.

13. In response, three significant initiatives emerged: sector reforms initiated by the World Bank; the strengthening of district health systems; and the Bamako Initiative.

A. World Bank sector reform

14. In 1987, the World Bank Policy Division identified the following three problems facing the health sector in developing countries: (a) insufficient allocation of public sector resources to the health sector; (b) inefficiency

of resource allocation within the health sector; and (c) inequity in the distribution of benefits from health services.

15. The Bank developed the following policy reforms in response: (a) charge fees to users of government facilities; (b) provide insurance cover or other risk cover; (c) use non-government resources effectively; and (d) decentralize government health services.

B. Strengthening of district health systems

16. In many countries, the paucity and lack of support from the central level resulted in the development of local initiatives to meet local health needs, with de facto decentralization of control. In several instances, this led to better local governance. Another positive outcome was the definition of the "district" as a management unit and the recognition of the need to strengthen support at the district level. The 1987 Harare Conference on District Strengthening, sponsored by WHO, was a milestone in the development of the concept. The key was to reduce the State's involvement in micro-management from the central level and put it squarely in the hands of local authorities with the means to implement action.

C. The Bamako Initiative

17. At a meeting of the WHO Regional Office for Africa in September 1987, building on the experience gained from interventions such as immunization and essential drugs programmes, African health ministers recognized the need to accelerate PHC and endorsed the concept of the Bamako Initiative. The Initiative is based on the principle of community participation in both financing and management of local health services, with decentralization of structures and authority and using the district as the main management unit. The purpose of the Initiative was to revive and strengthen collapsing health systems. Ensuring the supply of low-cost essential drugs would help to improve the quality of care provided and serve to attract community investment in health services.

III. SUSTAINABILITY: A UNICEF CHALLENGE

18. The three principal challenges to UNICEF in the 1990s are: (a) to help sustain the achievements of the 1980s, especially UCI and measures to reduce infant and child mortality; (b) to help improve and extend structures and systems that can ultimately sustain country achievements; and (c) to help build the capacity for priority activities initiated by countries to meet their goals and strategies for the 1990s. The following brief discussion of UCI and UCI Plus, the Bamako Initiative and UNICEF efforts to promote an integrated approach and national capacity-building reflects the experience and response of UNICEF to the three challenges.

A. Universal child immunization and UCI Plus

19. The UNICEF health agenda for the 1990s will work not only towards sustaining UCI, but also towards broadening it into UCI Plus in the context of establishing PHC as the basic pillar of the health care system. It will support the establishment and strengthening of health care systems, with a necessary focus on the greater integration of services based on maternal and child health (MCH) and women's health and within a broad-based approach of capacity-building and human resources development, in order to establish an adequate and sustainable response to health systems development. The major effort will be to extend and transform UCI structures into PHC structures, focusing essentially on the six big killers of children and women: vaccine-preventable diseases; diarrhoeal diseases; acute respiratory infections (ARI); malaria; human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS); and perinatal problems and women's health issues (encompassed under safe motherhood). These structures would benefit from coordinated action in the area of planning, supervision, training, support and information management.

20. In sustaining UCI, the principal recurrent costs are likely to be for vaccines and other local expenses. In better-off countries, local recurrent costs are increasingly funded through national or local financing. For example, in order to sustain continued immunization, communities in Kenya have expressed a willingness to use community-generated funds to help finance immunization sessions and to contribute to worker per diems and fuel costs in order that the frequency of immunization services can be maintained. Support for vaccine procurement is more difficult, however, because foreign exchange is required. The current UNICEF strategy for vaccine support has three elements: (a) support for local production in large countries with manufacturing capacity, especially through mobilizing the resources of the World Bank, regional development banks, etc.; (b) promotion of the Vaccine Independence Initiative, approved by the Executive Board in 1991 (E/ICEF/1991/P/L.41), under which vaccines are procured through UNICEF by Governments or national entities with foreign exchange or local currencies, which UNICEF, together with other development agencies, then uses for local purchases and expenses; and (c) continued provision of vaccines to countries not included in the first two categories.

21. Low-income countries will need continued support to meet the recurrent costs involved, most likely until the end of the century. The challenge to all donors will be to demonstrate the willingness to make long-term commitments until the end of the decade. At the country level, this would imply that donor assistance would be coordinated by the recipient Government and that the donor would accept this government coordination.

B. The Bamako Initiative

22. The Bamako Initiative is an approach to revitalizing, improving and extending sustainable health structures. As essential drugs are the main

component for improving quality of care, the Initiative promotes national drug policies based on the rational use of essential drugs.

23. In 1988, eight basic principles of the Bamako Initiative were elaborated:

(a) National commitment to accelerating the provision of universally accessible PHC services;

(b) Substantial decentralization to the district level of the health ministry's decision-making for the management of PHC;

(c) Decentralized management of community resources, allowing the funds collected at local facilities to remain under community control;

(d) The application of consistent principles for community financing of health care services throughout different levels of the health system, making it inappropriate to provide free services at urban hospitals while requiring payment for community-based services;

(e) Substantial government financial support for PHC to ensure that the health budget is maintained at least at its current level of support to district and local services;

(f) Essential drugs policies that are compatible with, and complementary to, the rational development of PHC;

(g) Measures for ensuring that the poorest people have access to PHC services;

(h) The clear definition of intermediate health systems and management objectives and the establishment of indicators to measure them.

24. The Bamako Initiative has evolved since its inception and is now being implemented in 33 countries. The latest developments of the Initiative are described in a separate report before the Executive Board (E/ICEF/1992/L.6). Although the Initiative's eight original principles have remained valid and have been promoted consistently, there have also been local variations in implementation, unique to each country and each community situation.

25. Also before the Executive Board is an executive summary of an evaluative review of the Initiative conducted by the London School of Hygiene and Tropical Medicine and based on case studies of Burundi, Guinea, Kenya, Nigeria and Uganda (E/ICEF/1992/L.20). The review, which was financed by the Governments of the United Kingdom, Denmark, Norway and Sweden, made 16 recommendations. The principal conclusion was that the following should be supported as an appropriate path towards the development of PHC: the strategy of revitalizing health services as defined by the features of community financing, community participation and national orientation; aims of improving quality and extending access; and strategic elements of management and accountability, together with the eight guiding principles of the Bamako

Initiative. The review also concluded that piecemeal and unbalanced approaches that omit some of these elements are inadequate.

26. The Bamako Initiative, which has been refined through experience since its endorsement by the Executive Board in 1988, is proving to be an effective approach for achieving sustainable health care systems that include both the curative and preventive aspects of health care.

C. Programme integration

27. While addressing the issue of support for the development of sustainable health structures, UNICEF has been coping with the issues of programme integration and national capacity-building. UNICEF programmes of cooperation have promoted integration both within and between sectors. While UCI and ORT have emerged as major components, country programmes also normally include other integrated CSD and MCH services in order to have a greater impact on the reduction of infant, child and maternal mortality.

28. The integration of programmes is also promoted across sectors. A typical CSD programme supported by UNICEF would thus be an integrated "package" with components for the principal child killers. The elements of such a package are most likely to be immunization for vaccine-preventable diseases; control programmes for diarrhoeal diseases, ARI, perinatal infections, malaria and AIDS; and supporting actions related to nutrition (including breast-feeding), water supply and sanitation, basic education, the role and status of women, communications, social mobilization and other interventions relevant to the national context.

29. UNICEF experience suggests that integration is most effective at the operational level and in situations where the national administrative structure is decentralized. The involvement of subnational-level administrations is essential to the process. At the central level, national bureaucracies are organized sectorally and vertically, and multisectoral coordination is best accomplished through national coordination mechanisms such as the offices of the President or Prime Minister, or the national planning commission or the governor's offices at the provincial level.

D. National capacity-building

30. In view of the importance of the availability of trained human resources, training has been a significant element of UNICEF programmes of cooperation since the mid-1970s, when the programme approach was adopted. An average 6 to 7 per cent of total programme expenditure was spent on training during each of the last five years, with $40 million spent per year in 1990 and 1991. UNICEF-supported training generally takes place at the operational level. Experience has shown that unless training is accompanied by close supervision and support, its impact may be limited and hard to sustain.

31. In the 1980s, the approach to human resources development in programmes was broadened to include more involvement and use of national institutions, universities and learned institutions and to use programme locations as training sites for university teaching. The disadvantaged counties project in China and the national capacity-building projects in Kenya and Uganda are some of the unique examples that close the gap between academia and development programming.

32. China's disadvantaged counties projects serves 300 underdeveloped counties. Health and nutrition activities are supported by medical universities and referral hospitals in research, training and evaluation, so that the projects developed reflect the epidemiological needs of each county and also receive support at each critical stage. University teaching is in turn enriched by involvement in actual field conditions.

33. The national capacity-building project in Uganda is also based on the premise of building linkages between universities, government health care institutions, health providers and communities. The project has established training and practice areas where future doctors and other health personnel learn by dealing with actual problems and tailor their research and teaching accordingly. The practice areas also benefit from the attention of these experts.

34. The experience of the Bamako Initiative has indicated that national capacity-building should also include local government and community levels, especially for strengthening management skills and for the experience required for better local governance, which can lead to better prospects for sustainable action. Especially at the community level, it has been found that the "triple-A" approach (assessment, analysis and action) to community capacity-building (especially in Iringa, United Republic of Tanzania, which is the most widely known example) can overcome a community's "fatigue" with development projects because there is local ownership and accountability, with a broad base of informed health care users.

35. An underrated aspect of national capacity-building appears to be technical cooperation among developing countries (TCDC) and within countries. TCDC provides not only a means of learning, but also a sense of competition between colleagues who try to outperform each other through improvements and innovations.

36. Some of the lessons learned from past experience about national capacity-building can be summarized as follows:

(a) National capacity-building needs to include both human resources development and institutional development;

(b) The development of human resources and institutions must include the strengthening of operational capacity and the means to provide adequate operational financing;

(c) Full involvement and operational partnerships are effective, but actual problem-solving appears to be the most effective form of training;

(d) Permanent dialogue and working relationships between professionals at different levels and in different institutional settings are more effective than sporadic missions;

(e) The retention of trained personnel remains a challenge because of increased social mobility, in addition to losses caused by out-migration and employment by donor agencies and private and external NGOs that offer more lucrative remuneration.

37. All human resources development and capacity-building activities must be viewed in the context of an emerging crisis in many countries because poorly trained and paid workers, who increasingly lack appropriate tools, are providing fewer quality services to the population.

IV. THE MAIN DIMENSIONS OF SUSTAINABILITY

38. Although sustainability has been associated primarily with financing, it has evolved into a broader concept. In many countries, sustaining health services is not simply a question of financing projects, but also one of the actual capacity to run the system. Many institutions have now come to view sustainability as the capacity of the health system to function effectively over time with a minimum of external input, although many doubt that this approach is realistic in view of the situation and pressing needs of low-income countries, especially in Africa. The experience of UNICEF suggests that a definition proposed by the International Development Management Center, University of Maryland (United States), based on its exploration of sustainability in several development sectors, is the most appropriate. According to that definition, sustainability is the ability of a system to produce benefits valued sufficiently by users and other stakeholders (actors other than users with an interest in what the system does) to ensure enough resources to continue activities with long-term benefits. The definition highlights sensitivity to client demand as well as the value assigned to output by various groups, including Governments, communities, donors and users.

39. It is now generally accepted that sustainability has five distinct yet interrelated key aspects: political; financial; managerial; technical; and cultural.

A. Political sustainability

40. Political commitment is the sine qua non of any successful, sustainable effort. It generates appropriate national policies, legislation and structural changes; supportive national and subnational budgets; and popular and social mobilization. Achieving political commitment is easier when there are feasible and realistic solutions to problems that have been identified as national priorities. National commitment to PHC can be translated into:

(a) The establishment of national policies and appropriate legislation, providing a legal framework;

(b) More balanced and equitable government budgets and staff allocations to PHC among both rural and urban communities;

(c) The restructuring of systems towards more decentralized management and local autonomy;

(d) The adoption of appropriate health and management technologies;

(e) Popular participation, with broader roles for community financing and management;

(f) Recognition of the role of NGOs and the private sector as partners;

(g) The involvement of the leaders of different sectors of society in PHC, including teachers, traditional and religious leaders and the media;

(h) Willingness to coordinate external support based on national PHC policies.

B. Financial sustainability

41. Financial sustainability is also crucial. Although a society cannot abdicate its responsibility to provide basic services to its population, current levels of government spending are insufficient to finance health needs fully, as indicated in a World Bank study on financing health services in developing countries. Because government budgets and services are unreliable and inadequate in many countries, partnerships have been organized with communities for the provision of basic health services. The Bamako Initiative is a good example of such a partnership, with decentralized structures providing better quality services under community management, financed by the community with support from central and local governments. Donor support is critical at the beginning of the partnership in order to improve the quality of care enough to attract community investment.

42. Because countries are at different stages of economic development, their health systems need different approaches. However, most countries could benefit from incorporating some or all of the following elements in their policy reform, thus contributing to the sustainability of health services:

(a) Establishing a system of community cost-sharing and management of health facilities and services, with measures to protect the poor;

(b) Encouraging the non-governmental sector (within an overall framework of national health care) to provide health services for users who are willing/able to pay;

(c) Decentralizing government health service operations, including planning, budgeting, decision-making and revenue retention at the local level. The central Government would focus more on national policy and management issues, such as the definition of service standards and technical norms at each level, a financing policy, development of monitoring and support arrangements, an essential drugs policy, the quality control and safety of pharmaceuticals, human resources development, research and vaccine procurement;

(d) Providing insurance or other risk coverage on a broad basis. A modest level of cost-recovery is possible without insurance, but in the long run, some form of insurance will be necessary for large segments of the population in order to relieve the government budget of the high costs of curative care.

43. A major focus in the area of financial sustainability should be on developing affordable systems with different means of support and built-in safety nets for the poor. The types of safety nets should be determined in accordance with the cultural milieu of each community. In many cultures, it is inappropriate to label a person publicly as "poor" and communities prefer that less-endowed members be supported through networks of extended families and kinship. Recent research from Cameroon has indicated that systems improved as part of the Bamako Initiative are actually used more by the poorest 20 per cent of the population because it is the only affordable option for them. However, this does not obviate the need to protect the real indigents.

44. A continuing challenge in the 1990s is likely to be the need for support for recurrent costs from donors. Because it is unlikely that many low-income countries will be able to absorb immediately all the recurrent costs incurred in the implementation of revitalized systems, an abrupt cessation of support for those costs could lead to the collapse of the systems. The best sustainable approach is likely to be one of long-term donor support on a sliding scale and the simultaneous development of domestic support systems.

C. Managerial sustainability

45. Managerial sustainability is imperative in order to maintain efficiency and adequate system performance levels. UNICEF experience has shown that management by objectives not only contributes to the achievement of established goals, but also produces a system of accountability, enhancing managerial sustainability. Good management systems (based on the setting of clear objectives and targets, action planning, budgeting, supply and logistics systems, human resources placement, training, supervision and information and monitoring systems) will ensure that the quality and effectiveness of services are established and maintained. Some key management factors that contribute to the efficiency and sustainability of health systems include:

(a) Decentralization of services accompanied by the decentralization of authority and institutional autonomy - creating community ownership - and establishment of accountability at different levels;

(b) Managerial leadership and availability of basic management skills (e.g. cost accounting) in the public and private sectors;

(c) Involvement of communities (especially women) in decision-making and in revenue-raising and retention;

(d) Role of the Government in policy-making, regulation and monitoring as opposed to providing services;

(e) Management information systems that encourage the use of information in decision-making at all levels, in addition to local research capacity, to make informed decisions.

D. Technical sustainability

46. If the systems and services sustained are to be effective, standards and performance indicators need to be established and applied. Technical sustainability is closely linked to the technology chosen for the systems. Many projects break down despite the existence of more appropriate alternatives because they rely on technology that is either too sophisticated for the existing infrastructure or too expensive to maintain. Non-medical technologies such as transportation are often as important as medical technologies as they also affect the functioning of the health system.

47. The choice of technology should be based on operations research and the potential for the local or regional provision or production of necessary supplies, equipment, spare parts and consumable goods. Some technical choices can also serve to reinforce sustainability: a disease surveillance system can be a foundation for future programmes; birth spacing has positive effects on long-term maternal health and infant mortality reduction; and a mass communications strategy can help to create demand for service delivery.

E. Cultural sustainability

48. Cultural values have a strong effect on all systems and initiatives that run counter to these values are harder to sustain. Local cultural and social values must be studied, understood and reflected in programme approaches and strategies. However, respect for cultural values should not ignore or reinforce negative cultural practices that threaten the life and well-being of people, especially women and girls.

49. In this context, the development of sustainability of health structures and systems can be seen as a process that requires learning from examples, experience and evaluation; is based on a partnership between the Government, communities and donors; takes into account the views and perceptions of both users and providers; looks beyond health sectors at broader societal factors; and is enhanced by enlightened demand creation through the empowerment of people.

V. STRATEGIES FOR ACHIEVING SUSTAINABILITY

A. Sector development

50. Within the framework of sector development, sustainability needs to be viewed in a broad context since it is the strength of the sector that will be under test. Sustainable development requires structures and systems that are capable of functioning effectively over time, taking into account political, financial, managerial, technical and cultural factors.

51. Sector development will also need to involve more efficient use of established infrastructures and services. There are increasing financial and resource constraints to the further development and expansion of facilities and services, including the need to cope with new diseases. For example, the impact of HIV/AIDS may need to be examined because of its potentially negative effect on sustainability through a disproportionate use of resources on AIDS patients. Issues related to equity must be addressed in order to reach underserved segments of the population, while priorities must be determined and interventions applied selectively in view of limited resources.

52. In the context of system building, it is crucial to recognize the role of socially active institutions, because without such institutions, which can plan and direct action, longer-term sustainability can be jeopardized.

B. Systems and structures with a purpose

53. Systems and structures are more effective, efficient and ultimately more sustainable when they have a purpose. Based on specific goals and targets, a purpose provides a specific context in which to work, encourages ownership and accountability and instils the practice of management by objectives. The systems and structures need to be supported by effective management information to facilitate sound decision-making and better governance.

54. Priority problems for the system should be defined by the people most closely associated and concerned with it, in the spirit of decentralization, while taking into account the countervailing forces that bear on decision-making. Overall national goals and targets would be most appropriately set at the national level, stimulated by global initiatives that may have the benefit of cross-country experience and knowledge and are based on well-accepted ethical considerations. National goal-setting also provides the possibility for mediation of the potential conflicts of community-induced goals. In this context, mortality reduction goals would necessarily relate to all the health system issues that need to be addressed as well as promote the possibility of profound change of perception in the community about health priorities and actions.

C. National capacity-building and strengthening of institutions

55. Creating sufficient capacity at the national level, in terms of deployment of human resources and institutional development, is crucial for sustainability. Such capacity-building should build on what already exists, taking into account community priorities in health. It is important to build national capacity using the ability to prioritize and make health development decisions based on accessible and reliable information. Conflict resolution, often involving local and national decisions, would be an important part of this work.

56. While better trained, located, supervised and remunerated human resources would be a principal purpose of national capacity-building, because the human factor is perhaps the most critical element of sustainability, it is also important that an enabling organizational setting be established for people and organizations to function effectively. Attention should also be paid to institution-building and strengthening so that institutions can provide continuity and improved effectiveness in building national capacity. An inventory of essential national capacities that would contribute to determining the sustainability of actions for improving health in developing countries is provided in the annex to the present report.

57. A key issue in institution-building is the dual role of health ministries as guardians of national health, both as public advocates and educators for better health and healthy living, and as guarantors of accessible health care for the sick and the disadvantaged through direct provision of services or appropriate subventions. The balance between the two roles and the way they are undertaken will determine a ministry's effectiveness in combating the nation's problems and cost-effectiveness in public sector health actions. It should be recognized that the public sector may not be very cost effective in the area of health if its main role is to provide services for the poorest and disadvantaged, whose care is often more expensive and who are often unable to contribute significant resources to health. Related to this changing matrix is the need to acknowledge the place of the private and non-governmental sectors as providers of health care.

D. Demand creation

58. Experience suggests that sustained demand stimulates sustained response. Demand creation is often described as a precondition for sustainable actions. It is important that priority action at national levels take into account, and balance with, other priorities at subnational and local levels so that an appropriate balance is maintained in each locale in demand creation efforts. Sustainability is normally a dynamic process that depends on the balancing of different countervailing forces, demands and viewpoints.

E. Health and health services

59. In considering sustainability, it is important to remember that health is broader than the mere delivery of health services. At present, ministries of health must play dual roles: as providers of health services with service outputs; and as public advocates and educators for better health and healthy living. The second role is equally, if not more important, given increasing restraints on health resources. Irrespective of the advocacy/service "mix", health ministries must increasingly act as "orchestrators", a strategic function, rather than solely as guardians of public health. Donors, on the other hand, can be advocates for better health, but each country must decide its own direction for restructuring and action. More donor sensitivity in this regard is needed, particularly as their collective financial influence tends to overwhelm Governments in low-income countries.

F. Integration at the operational level

60. For systems to be effective, their elements need to be integrated at the operational level, which is cost-effective, synergistic in outcome and more efficient. As financial resources are likely to be scarce during the 1990s, even with a commitment to greater efficiency, there will not be sufficient resources for all desirable health actions. Communities will likely be obliged to select actions, and be more likely to invest in the aspects of care they viewed as most critical, while bearing in mind that 80 per cent of system users are children and women.

VI. CONCLUSIONS: PREREQUISITES OF SUCCESS

61. In the context of national capacity-building and institution strengthening leading to the sustainability of systems and structures, some of the prerequisites for success would include:

(a) Advocacy for "health as investment", taking into account the prevailing forces that are concerned with health in a country;

(b) Decentralization of administrative structures and strengthening of community structures;

(c) Mobilization of resources, including cash;

(d) Establishing and strengthening systems that deliver specific outcomes;

(e) Streamlining processes that enable the introduction of delivery systems;

(f) Strengthening and supporting institutions ready to bring about these processes of change.

62. Those six points of action represent the UNICEF agenda for supporting sustainable health action for incorporation into country programmes of cooperation.

63. Within this framework, desirable system changes would include: (a) establishment of clearer standards for the effectiveness and coverage of health care services; (b) setting performance indicators for cost-effectiveness; (c) the introduction of financial controls; (d) greater responsiveness to health workers' needs; (e) increased focus on the performance of personnel; (f) systems that deal with and support infrastructure maintenance; (g) sensitivity to users' needs and demands; and (h) the incorporation of community organization.

64. Sustainability is complex and not without certain potential contradictions. The need for organizational decentralization should be viewed against the need to maintain services of a reasonable quality. Similarly, the need to attain financial efficiency in a resource scarce environment should be weighed against the desire to pursue equitable development, particularly for the poorest, who are least likely to be able to contribute to the costs of health care. These are some of the longer-term structural and ethical issues that still need to be addressed more comprehensively. There is clearly a need for collective thinking by all concerned because policies and actions necessary for building sustainable systems are likely to have political costs that cannot be ignored. Therefore, appropriate incentives will have to be found so that a broad alliance can be established to facilitate change.

Annex

SUSTAINABILITY OF ACTIONS TO IMPROVE HEALTH IN DEVELOPING COUNTRIES: AN INVENTORY OF ESSENTIAL NATIONAL CAPACITIES

In any situation, there will be a need to prioritize and select capacities that need development.

I. Conceptual, policy-making and planning capacities

A. Analysis

1. Analyse the health status of different groups in society;

2. Identify causes of ill-health;

3. Assess perceptions of ill-health;

4. Quantify health-seeking behaviours;

5. Examine access to services (public/private, traditional/modern);

6. Community management and communication systems (need for policy makers and planners to be able to commission analyses and for researchers to deliver useful products in response).

B. Priority setting

1. Prioritize health problems at different levels (community/district/national);

2. Seek legitimization of priorities in different (participatory) forums;

3. Establish again at different levels and legitimize goals and strategies to tackle priorities;

4. Select and incorporate in strategies, cost-effective interventions and delivery systems;

5. Seek and obtain finance from a mixture of public and private sources. (Need for a variety of groups both within and outside government to establish this capacity.)

C. Communication

1. Communicate policies, goals and strategies to all interested parties, promoting participation where possible;

2. Establish mechanisms for regular review by legitimizing forums as identified above.

II. Service provision capacities

Agencies that are mandated or contracted to provide services should be able to:

1. Set standards for services provision, according to agreed policies, goals and strategies;

2. Devise efficient methods for ensuring that people receive services according to the agreed standard, through public and/or private providers;

3. Secure finance for, deliver and monitor services, with regular assessments of quality, effectiveness and cost;

4. Ensure equity of service provision, so that disadvantaged people have the services they need, when they need them.

III. Management capacities

Agencies mandated or contracted to provide services must be able to:

1. Devise procedures to deal with demands of varying complexity, establishing referral networks (and standards for referral);

2. Establish systems for supply (procurement and distribution), transportation, information collection and analysis, etc.;

3. Establish systems for investigating instances where standards are not being maintained and for introducing corrective action;

4. Establish systems to safeguard the interests of all personnel - including professionals - and to ensure that no one group has a disproportionate influence on priorities or activities;

5. Establish systems for delegating control over service provision to the local level, wherever possible.

IV. Institutional capacities

A. In-country institutional capacity is needed to:

1. Monitor policy development and implementation through research and dialogue;

2. Establish training needs and ensure that service providers, researchers and policy makers at all levels receive the training they require;

3. Monitor and evaluate system/service delivery performance;

4. Relate to donors, industry and other parties who have an interest in national health issues, ensuring that these external bodies are not able to distort local or national priorities, goals or strategies.

B. A number of external contextual factors will influence whether or not these in-country capacities will facilitate sustainable health development. These include:

1. Public sector regulations and procedures: the progress of public sector reforms;

2. Budgeting, auditing and accounting processes in the public sector;

3. National policies for decentralization or centralization, and their implementation;

4. National policies for deregulation, privatization and/or contracting out, and their implementation;

5. National, regional and local mechanisms for generating, and responding to, public pressures, advocacy and lobbies;

6. Donor coordination mechanisms.

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